FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041608

Facility Name: ASTA CARE CENTER OF ELGIN

Address: 134 NORTH MCLEAN BOULEVARD (Number) ELGIN (City) 60123 (Zip Code)

County: KANE

Telephone Number: (847) 742-8822 **Fax #** (847) 742-9013

IDPA ID Number: 36-4069629

Date of Initial License for Current Owners: 03/29/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MICHAEL GILLMAN
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,672		2,219	3,891	8
9	SNF/PED					9
10	ICF	22,164	2,055	2,723	26,942	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,836	2,055	4,942	30,833	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.82%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 03/29/96

J. Was the facility purchased or leased after January 1, 1978?

YES [X] Date 03/29/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?

YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 2,219

Medicare Intermediary SD`ADMINISTAR OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	233,240	17,025	6,520	256,785		256,785		256,785			1
2	Food Purchase		141,710		141,710		141,710	(2,026)	139,684			2
3	Housekeeping	233,014	22,718		255,732		255,732		255,732			3
4	Laundry	61,004	14,986		75,990		75,990		75,990			4
5	Heat and Other Utilities			96,979	96,979		96,979		96,979			5
6	Maintenance	43,219	23,364	21,338	87,921		87,921	(21)	87,900			6
7	Other (specify):*			20,043	20,043		20,043		20,043			7
8	**TOTAL General Services**	570,477	219,803	144,880	935,160		935,160	(2,047)	933,113			8
	B. Health Care and Programs											
9	Medical Director			11,750	11,750		11,750		11,750			9
10	Nursing and Medical Records	1,285,632	86,761	14,772	1,387,165		1,387,165		1,387,165			10
10a	Therapy		2,640	7,000	9,640		9,640		9,640			10a
11	Activities	108,562	10,918	936	120,416		120,416		120,416			11
12	Social Services	56,071		4,539	60,610		60,610		60,610			12
13	CNA Training											13
14	Program Transportation			917	917		917		917			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,450,265	100,319	39,914	1,590,498		1,590,498		1,590,498			16
	C. General Administration											
17	Administrative	28,052		195,000	223,052		223,052	(49,761)	173,291			17
18	Directors Fees											18
19	Professional Services			33,666	33,666		33,666	1,829	35,495			19
20	Dues, Fees, Subscriptions & Promotions			36,488	36,488		36,488	(14,659)	21,829			20
21	Clerical & General Office Expenses	79,310	26,344	41,484	147,138		147,138	(3,188)	143,950			21
22	Employee Benefits & Payroll Taxes			279,854	279,854		279,854		279,854			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,052	6,052		6,052		6,052			24
25	Other Admin. Staff Transportation			1,429	1,429		1,429	3,633	5,062			25
26	Insurance-Prop.Liab.Malpractice			133,977	133,977		133,977	692	134,669			26
27	Other (specify):*			32,051	32,051		32,051	(22,627)	9,424			27
28	**TOTAL General Administration**	107,362	26,344	760,001	893,707		893,707	(84,081)	809,626			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,128,104	346,466	944,795	3,419,365		3,419,365	(86,128)	3,333,237			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: ASTA CARE CENTER OF ELGIN #0041608 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,000	
	REPAIRS & MAINTENANCE		640	
	OUTSIDE SERVICES		880	6,520
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		35,872	
	ELECTRICITY		34,750	
	WATER		26,357	
	CABLE TV - LOBBY		0	
			0	96,979
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,402	
	PAINTING & DECORATING		1,757	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,232	
	ELEVATOR MAINTENANCE & REPAIR		1,754	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,375	
	FIRE SERVICE		3,818	
			0	
			0	
			0	21,338
7	**OTHER**			
	SCAVENGER		20,043	
	SECURITY SERVICE		0	20,043
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	11,750	11,750

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		90	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	1,728	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,504	
	PHARMACY CONSULTANT	XVIII B 39-2	1,950	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	4,000	
	RN CONSULTANT	XVIII B 38-2	0	
	PROGRAM CONSULTANT		5,500	
			0	14,772
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	7,000	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	7,000
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	936	
			0	936
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	4,539	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	4,539
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASTA CARE CENTER OF ELGIN **#0041608** **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		917	917
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	195,000	195,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	9,580	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	24,086	
			0	33,666
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	14,362	
	EMPLOYEE WANT ADS	XIX F	4,450	
	CONTRIBUTIONS	VI 20 XIX F	1,550	
	DUES & SUBSCRIPTIONS	XIX F	7,073	
	LICENSES & PERMITS	XIX F	7,770	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	10	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,273	36,488
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,053	
	EQUIPMENT REPAIR & MAINTENANCE		851	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		36,531	
	MESSENGER SERVICE		1,049	
			0	41,484

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	159,506	
	UNEMPLOYMENT COMPENSATION	XIX D	29,161	
	WORKERS COMPENSATION INSURANCI	XIX D	44,245	
	HOSPITALIZATION INSURANCE	XIX D	38,698	
	EMPLOYEE BENEFITS - OTHER	XIX D	7,408	
	EMPLOYEE PHYSICAL EXAMS	XIX D	836	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	279,854
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	6,052	
	TRAVEL	XIX G	0	
			0	
			0	6,052
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,429	1,429
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		133,977	133,977
27	**OTHER**			
	BAD DEBTS	VI 24	32,051	
				32,051

GRAND TOTAL COLUMN 3 OTHER 944,795

ASTA CARE CENTER OF ELGIN
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	141,710	PATIENT MEALS	92499
LESS SALES TAX	(2,026)	ADD EMPLOYEE MEALS	0
NET FOOD	139,684	TOTAL MEALS/YEAR	92499
TOTAL PATIENT CENSUS	30,833	NET FOOD	139684
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	92499
TOTAL PATIENT MEALS	92499	COST PER MEAL	1.51
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number ASTA CARE CENTER OF ELGIN #0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			31,555	31,555		31,555	9,122	40,677			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,337	46,337		46,337	(48)	46,289			32
33	Real Estate Taxes			79,133	79,133		79,133		79,133			33
34	Rent-Facility & Grounds			464,280	464,280		464,280		464,280			34
35	Rent-Equipment & Vehicles			17,734	17,734		17,734	1,338	19,072			35
36	Other (specify):* **amort comp. software**			267	267		267		267			36
37	**TOTAL Ownership**			639,306	639,306		639,306	10,412	649,718			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		84,515	182,471	266,986		266,986		266,986			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		84,515	238,316	322,831		322,831		322,831			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,128,104	430,981	1,822,417	4,381,502		4,381,502	(75,716)	4,305,786			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,122	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,026)	2		13
14	Non-Care Related Interest	(48)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,550)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,051)	27		24
25	Fund Raising, Advertising and Promotional	(14,362)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(10)	20		28
29	Other-Attach Schedule	(15,738)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,663)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(19,053)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (19,053)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (75,716)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ASTA CARE CENTER OF ELGIN

ID# 0041608

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (21)	6	1
2	BANK CHARGES	(3,053)	21	2
3	MARKETING TRAVEL	(697)	25	3
4	MARKETING SALARY	(11,967)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(15,738)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,026)	0	0	0	0	0	0	0	0	0	0	(2,026)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(21)	0	0	0	0	0	0	0	0	0	0	(21)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,047)	0	0	0	0	0	0	0	0	0	0	(2,047)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(49,761)	0	0	0	0	0	0	0	0	0	(49,761)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,829	0	0	0	0	0	0	0	0	0	1,829	19
20	Fees, Subscriptions & Promotions	(15,922)	1,263	0	0	0	0	0	0	0	0	0	(14,659)	20
21	Clerical & General Office Expenses	(15,020)	11,832	0	0	0	0	0	0	0	0	0	(3,188)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(697)	4,330	0	0	0	0	0	0	0	0	0	3,633	25
26	Insurance-Prop.Liab.Malpractice	0	692	0	0	0	0	0	0	0	0	0	692	26
27	Other (specify):*	(32,051)	9,424	0	0	0	0	0	0	0	0	0	(22,627)	27
28	TOTAL General Administration	(63,690)	(20,391)	0	0	0	0	0	0	0	0	0	(84,081)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(65,737)	(20,391)	0	0	0	0	0	0	0	0	0	(86,128)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,122	0	0	0	0	0	0	0	0	0	0	9,122	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48)	0	0	0	0	0	0	0	0	0	0	(48)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,338	0	0	0	0	0	0	0	0	0	1,338	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,074	1,338	0	0	0	0	0	0	0	0	0	10,412	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(56,663)	(19,053)	0	0	0	0	0	0	0	0	0	(75,716)	45

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				ASTA HEALTHCARE	ELGIN	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 195,000	ASTA HEALTHCARE COMPANY, INC.		$	$ (195,000)	1
2	V	17	OFFICERS SALARY-MG				37,408	37,408	2
3	V	17	OFFICERS SALARY-SETH				30,101	30,101	3
4	V	17	ADMIN. SALARY-CF				25,749	25,749	4
5	V	17	ADMIN. SALARY-DM				26,274	26,274	5
6	V	17	ADMIN. SALARY				25,707	25,707	6
7	V	19	PROFESSIONAL FEES				1,829	1,829	7
8	V	20	DUES & SUBSCRIPTIONS				1,263	1,263	8
9	V	21	OFFICE EXPENSE				11,832	11,832	9
10	V	25	AUTO & TRAVEL				4,330	4,330	10
11	V	26	INSURANCE GEN & W/C				692	692	11
12	V	27	PAYROLL TAX & EMPL BEN				9,424	9,424	12
13	V	35	EQUIPMENT RENTAL				1,338	1,338	13
14	Total			$ 195,000			$ 175,947	$ * (19,053)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MICHAEL GILLMAN			40.00					$		1
2	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE $210,000							SALARY	37,408	17-7	2
3											3
4	SETH GILLMAN										4
5	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE $168,982							SALARY	30,101	17-7	5
6											6
7	CRAIG FRANK										7
8	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE $144,547							SALARY	25,749	17-7	8
9											9
10	DAVID MEISELMAN							SALARY	28,052	17-1	10
11	TOTAL SALARY RECEIVED FROM ASTA HEALTHCARE $147,499							SALARY	26,274	17-7	11
12	ALIZA FRANK-TOTAL SAL. RECEIVED FR ASTA HEALTH $27,096							SALARY	4,827	21-7	12
13								TOTAL	$ 152,411		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ASTA HEALTHCARE COMPANY
Street Address: 134 NORTH MCLEAN BLVD
City / State / Zip Code: ELGIN, IL 60123
Phone Number: (847) 742 - 8822
Fax Number: (847) 742 - 9013

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY-MG	PATIENT DAYS	173,090	6	$ 210,000	$ 210,000	30,833	$ 37,408	1
2	17	OFFICERS SALARY-SETH	PATIENT DAYS	173,090	6	168,982	168,982	30,833	30,101	2
3	17	ADMIN. SALARY-CF	PATIENT DAYS	173,090	6	144,547	144,547	30,833	25,749	3
4	17	ADMIN. SALARY-DM	PATIENT DAYS	173,090	6	147,499	147,499	30,833	26,274	4
5	17	ADMIN. SALARY	PATIENT DAYS	173,090	6	144,315	144,315	30,833	25,707	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	173,090	6	10,265		30,833	1,829	6
7	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	173,090	6	7,090		30,833	1,263	7
8	21	OFFICE EXPENSE	PATIENT DAYS	173,090	6	66,421	27,096	30,833	11,832	8
9	25	AUTO & TRAVEL	PATIENT DAYS	173,090	6	24,306		30,833	4,330	9
10	26	INSURANCE GEN & W/C	PATIENT DAYS	173,090	6	3,885		30,833	692	10
11	27	PAYROLL TAX & EMPL BEN	PATIENT DAYS	173,090	6	52,906		30,833	9,424	11
12	35	EQUIPMENT RENTAL	PATIENT DAYS	173,090	6	7,509		30,833	1,338	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 987,725	$ 842,439		$ 175,947	25

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	BED TAX		X	INT ON BED TAX							3,489	5
	Working Capital											
6	BANK ONE		X	WORKING CAPITAL	INTEREST	REVOLV	375,000	450,000	REVOLV	PRIME +	35,210	6
7	WELLS FARGE		X	ALARM SYSTEM	$614.00	01/20/02	36,870	7,989	02/20/07	0.0621	705	7
8	INSURANCE		X	INT ON INS POLICIES							6,933	8
9	TOTAL Facility Related				$614.00		$ 411,870	$ 457,989			$ 46,337	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 411,870	$ 457,989			$ 46,337	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	71,235	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	75,184	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,949	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	75,184	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	79,133	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	61,231	8
	2001	63,122	9
	2002	68,219	10
	2003	71,235	11
	2004	75,184	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASTA CARE CENTER OF ELGIN COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0041608

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-15-176-011	NURSING HOME	$ 68,681.76	$ 68,681.76
2.	06-15-176-043	NURSING HOME	$ 872.64	$ 872.64
3.	06-15-176-044	NURSING HOME	$ 5,629.48	$ 5,629.48
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,183.88	$ 75,183.88

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOOR DRAIN			1997	1,297	33	39	33		282	9
10	INSTALL SHOWER VALVE AND DRAIN			1997	4,142	105	39	105		898	10
11	RE KEY DOOR LOCKS			1997	4,085	104	39	104		889	11
12	NEW AIR VENTS			1997	616	18	39	18		153	12
13	FIRE ALARM SYSTEM			1997	2,192	56	39	56		478	13
14	AWNINGS			1997	1,020	26	39	26		222	14
15	SEWAGE EJECTOR PUMP			1998	3,961	102	39	102		777	15
16	HOT WATER PUMP			1998	5,439	139	39	139		1,002	16
17	AWNINGS			1999	685	25	27.5	25		164	17
18	FLOORING			1999	2,474	90	27.5	90		589	18
19	ELECTRICAL WORK			1999	9,378	341	27.5	341		2,231	19
20	MAGNETIC DOOR LOCKS			1999	2,054	74	27.5	74		484	20
21	FIRE SPRINKLER SYSTEM			1999	3,868	141	27.5	141		922	21
22	BOILER			1999	4,890	178	27.5	178		1,164	22
23	NURSE STATION			2000	16,280	592	27.5	592		3,281	23
24	CONDENSING UNIT			2000	4,683	170	27.5	170		942	24
25	WATER HEATER			2000	8,731	317	27.5	317		1,757	25
26	POWER VENT FOR WATER HEATER			2000	2,682	98	27.5	98		543	26
27	NEW WALLS			2000	2,000	73	27.5	73		404	27
28	HOT WATER PIPING			2000	4,708	171	27.5	171		948	28
29	DRAPERIES			2000	2,303	203	7	203		2,047	29
30	EJECTOR PUMP			2001	14,041	511	27.5	511		2,321	30
31	ROOF			2001	6,218	226	27.5	226		1,026	31
32	COMPRESSOR			2001	3,501	127	27.5	127		577	32
33	PRESSURE BACK FLOW PREVENTER			2002	3,870	141	27.5	141		499	33
34	FIRE ALARM SYSTEM			2002	37,625	1,368	27.5	1,368		4,845	34
35	RE KEY LOCKS			2002	1,346	49	27.5	49		174	35
36	PATIENT SECURITY SYSTEM			2002	2,719	99	27.5	99		350	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	2002	$ 4,864	$ 177	27.5	$ 177	$	$ 627	37
38	NEW PIPE	2002	1,575	57	27.5	57		202	38
39	VINYL FLOORING	2002	17,779	1,434	5	3,556	2,122	14,224	39
40	HANDRAILS,BUMPERS,CORNER	2003	17,903	651	27.5	651		1,655	40
41	SMOKE DAMPERS	2003	1,904	69	27.5	69		175	41
42	DOOR ALARM SYSTEM	2003	3,097	113	27.5	113		287	42
43	SMOKING PORCH	2003	764	28	27.5	28		71	43
44	WALLCOVERINGS & PAINTING	2003	26,197	3,521	5	5,239	1,718	15,717	44
45	DIALYSIS ROOM	2004	23,267	846	27.5	846		1,304	45
46	VALVE ACTUATOR	2004	3,240	118	27.5	118		123	46
47	HOT WATER HEATER	2004	6,837	248	27.5	248		258	47
48	CURTAINS	2005	1,513	303	5	303		303	48
49	FIRE ALARM SYSTEM	2005	4,026	79	27.5	79		79	49
50	SPRINKLER HEADS	2005	2,530	50	27.5	50		50	50
51	FIRE DOOR	2005	547	11	27.5	11		11	51
52	ASPHALT	2005	6,000	217	15	217		217	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 278,851	$ 13,499		$ 17,339	$ 3,840	$ 65,272	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 224,005	$ 14,309	$ 22,401	$ 8,092	10 YRS	$ 133,477	71
72	Current Year Purchases	18,737	3,747	937	(2,810)	10 YRS	937	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 242,742	$ 18,056	$ 23,338	$ 5,282		$ 134,414	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 521,593	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 31,555	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 40,677	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,122	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 199,686	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ELGIN NURSING HOME PROPERTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		102		$ 464,280	30		3
4	Additions							4
5								5
6								6
7	TOTAL		102		$ 464,280 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 03/26/96
Ending 03/26/26

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$ 461,862
13.	/2007	$ 461,862
14.	/2008	$ 461,862

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 10,379 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$ 7,355	17
18					18
19					19
20					20
21	TOTAL		$	$ 7,355	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 58,226	$		$ 58,226	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			14,475			14,475	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			103,886			103,886	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				73,020		73,020	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	laboratory, radiology Other (specify): supplies	39-8				5,884	11,495		17,379	13
14	TOTAL			$		$ 182,471	$ 84,515		$ 266,986	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 169,915	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,035,888		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,222		6
7	Other Prepaid Expenses	9,224		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE ESCROW DEPOSIT	20,280		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,268,529	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	231,059		15
16	Equipment, at Historical Cost	305,272		16
17	Accumulated Depreciation (book methods)	(296,447)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 239,884	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,508,413	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,046,379	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	457,989		29
30	Accrued Salaries Payable	63,397		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,726		31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,184		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,653,675	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	561,408		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 561,408	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,215,083	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (706,670)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,508,413	$	48

***(See instructions.)**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (538,531)	1
2	Restatements (describe):		2
3	ROUNDING	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (538,527)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(168,143)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (168,143)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (706,670)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,895,210	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,895,210	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	319,242	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 319,242	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,090	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,090	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR EXPENSE	(2,231)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (2,231)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,213,359	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	935,160	31
32	Health Care	1,590,498	32
33	General Administration	893,707	33
	B. Capital Expense		
34	Ownership	639,306	34
	C. Ancillary Expense		
35	Special Cost Centers	266,986	35
36	Provider Participation Fee	55,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,381,502	40
41	**Income before Income Taxes (line 30 minus line 40)****	(168,143)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (168,143)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,034	2,227	$ 98,501	$ 44.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,688	10,419	340,229	32.65	3
4	Licensed Practical Nurses	10,987	11,674	293,837	25.17	4
5	CNAs & Orderlies	45,077	46,129	514,517	11.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,959	2,173	34,654	15.95	9
10	Activity Assistants	7,599	8,144	73,908	9.08	10
11	Social Service Workers	2,664	2,779	56,071	20.18	11
12	Dietician					12
13	Food Service Supervisor	1,935	2,254	46,637	20.69	13
14	Head Cook	13,190	14,831	158,924	10.72	14
15	Cook Helpers/Assistants	3,468	3,847	27,679	7.19	15
16	Dishwashers					16
17	Maintenance Workers	2,042	2,300	43,219	18.79	17
18	Housekeepers	22,909	25,712	233,014	9.06	18
19	Laundry	6,402	6,953	61,004	8.77	19
20	Administrator	1,935	1,935	28,052	14.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	423	553	15,014	27.15	23
24	Clerical	3,636	4,005	64,296	16.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,765	2,142	38,548	18.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,713	148,077	$ 2,128,104 *	$ 14.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly fee	$ 5,000	1-3	35
36	Medical Director	monthly fee	11,750	9-3	36
37	Medical Records Consultant	monthly fee	1,504	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	1,950	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	monthly fee	936	11-3	44
45	Social Service Consultant	monthly fee	4,539	12-3	45
46	Other(specify) Psychiatric consult	monthly fee	4,000	10-3	46
47	Program consultant	monthly fee	5,500	10-3	47
48	Rehab Consultant	monthly fee	7,000	10a-3	48
49	TOTAL (lines 35 - 48)		$ 42,179		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DAVID MEISELMAN	ADMIN		$ 28,052
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 28,052

B. Administrative - Other

Description	Amount
ASTA HEALTH CARE MGMT - MANAGEMENT FEE	$ 195,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 195,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ENLOE DRUGS	DATA PROCESSING	$ 1,800
HEALTH DATA SYSTEMS	DATA PROCESSING	7,691
ASTA CARE CENTER	DATA PROCESSING	355
KRUPNICK BOKOR	ACCOUNTING	16,800
HEALTH RECEIVABLES MGMT	LEGAL FEES	350
STONE, MCGUIRE & BENJAMIN	LEGAL FEES	1,240
CHARLES BUTZOW	ARCHITECT	823
JOYCE DAVIDSON	MEDICAL RECORDS CONSLT	237
PERSONNEL PLANNERS	UC CONSULTANT	1,620
RICHARD PEELO	MEDICARE CONSULTANT	2,750
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 33,666

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 44,245
Unemployment Compensation Insurance		29,161
FICA Taxes		159,506
Employee Health Insurance		38,698
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		7,408
EMPLOYEE PHYSICAL EXAMS		836
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 279,854

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	4,450
Health Care Worker Background Check	1,273
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	14,372
TRUST/FRANCHISE/CONTRIB/ETC	1,550
LICENSES & PERMITS	6,775
DUES & SUBSCRIPTIONS	7,073
MGMT CO ALLOCATION	1,263
TRUST/FRANCHISE/CONTRIB/ETC	(1,550)
Less: Public Relations Expense	(0)
Non-allowable advertising	(14,362)
Yellow page advertising	(10)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,829

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	6,052
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,052

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINTING/DECORATIN	1998	$ 1,623	3 YRS	$	$	$	$	$	$	$	$	$
2	PAINTING/DECORATIN	1999	1,843	3 YRS	308								
3	PAINTING/DECORATIN	2000	7,149	3 YRS	2,383	1,191							
4	PAINTING/DECORATIN	2001	3,139	3 YRS	1,046	1,046	523						
5	PAINTING/DECORATIN	2002	2,562	3 YRS	427	854	854	427					
6	PAINTING/DECORATIN	2004	3,049	3 YRS			509	1,016	1,016	508			
7	PAINTING/DECORATIN	2005	1,757	3 YRS				293	586	586	292		
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 21,122		$ 4,164	$ 3,091	$ 1,886	$ 1,736	$ 1,602	$ 1,094	$ 292	$	$

Facility Name & ID Number ASTA CARE CENTER OF ELGIN # 0041608 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC $3,320**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **NO**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,695** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **55,845**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees